MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11227

CERTIFICATE OF DEATH

11216

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6mos. 11days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 20
d. STREET ADDRESS: R#16, Box 331
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Harry — Last: Austraw, Sr.

4. DATE OF DEATH: October 15, 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 5, 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: Bethlem Steel

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Austraw

14. MOTHER'S MAIDEN NAME: Susannah Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No / -

16. SOCIAL SECURITY NO.: 213-07-0785

17. INFORMANT Address: Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Urinary tract infection.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

609X

INTERVAL BETWEEN ONSET AND DEATH: Days. / Week.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. with senile brain disease with psychotic reaction. Cyst in left kidney.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 1, 1961 to October 15, 1961, that (I) (we) last saw the deceased alive on October 15, 1961, and that death occured at 11:50PM from the causes and on the date stated above.

22a. SIGNATURE: Naci Buyukunsal M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/16/61

22c. PHYSICIAN'S NAME (Type): Naci Buyukunsal, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-19-1961

23c. NAME OF CEMETERY OR CREMATORY: Zion Luthern Cemetery

23d. LOCATION (City, town or county) (State): Stemmers Run Md

24 FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home

ADDRESS: 7461 Belair Road

25a. REC'D BY REGISTRAR DATE: OCT 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228

CERTIFICATE OF DEATH

Reg. Dist. No. 11217

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) Rural--Sykesville
c. LENGTH OF STAY IN 1b 3yr.4mo.8dys.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY —
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) Baltimore 3V01-4
d. STREET ADDRESS 907 W. 34th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Marie Middle Tressa Last Ayers

4. DATE OF DEATH Month 10 Day 26 Year 1961

5. SEX female

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9/17/93

9. AGE (In years lost birthday) 68 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Stote or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Treshmann

14. MOTHER'S MAIDEN NAME ? French

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Springfield records Address Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

420.0

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

DUE TO (b) Arteriosclerotic heart disease including coronary disease. — years

DUE TO (c) Generalized arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition with presenile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I/we attended the deceased from 6/18/ 1958, to 10/26/ 1961, that I/we last saw the deceased alive on 10/26/ 1961, and that death occurred at 2 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Rita S. Glahn M.D. ADDRESS (Street, city or town, stote) Springfield State Hospital DATE SIGNED 10/26/61

PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-30-61

22c. NAME OF CEMETERY OR CREMATORY Parkwood

22d. LOCATION (City, town, or county) Balt City (Stote) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Frank H Seitz ADDRESS 814 W 36 St

24a. REC'D BY REGISTRAR DATE OCT 30 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229

CERTIFICATE OF DEATH

Reg. Dist. No. 11218

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [redacted] Westminster
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. #5 Westminster
d. STREET ADDRESS: UNIONTOWN ROAD [redacted]
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ruth	Elizabeth	Baust	10	13	1961

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W		9/26/29	32 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	OWN --- HOME	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ORLANDO FARVER	MAE FRIZZELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
NO	NONE	RALPH E BAUST WESTMINSTER, MD R5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Generalized peritonitis (Ruptured)
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pregnancy - 8 months. — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/5, 19 61, to 10/13, 19 61, that I last saw the deceased alive on 10/13, 19 61, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard G. Dalrymple M.D. — ADDRESS (Street, city or town, state): 25 Smith Ave. Westminster, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): RICHARD G. DALRYMPLE M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	OCT 16 1961	LUTHERAN	UNIONTOWN MD

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
C D Hartzler & Sons	New Windsor Md	OCT 17 '61	Arthur L. Kime

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11230

CERTIFICATE OF DEATH

11219

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville, Md.
c. LENGTH OF STAY IN 1b: 1yr. 11mo. 2d.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: 127 North Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print): First: Charles — Middle: Edward — Last: Beatty

4. DATE OF DEATH: Month: 10 — Day: 10 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-29-1893

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry J. Beatty

14. MOTHER'S MAIDEN NAME: Catherine Cassell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

4 16 7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Manic Depressive Reaction, manic type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): --

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --

20f. (City or town) (County) (State): --

21. I certify that (I) (this hospital) attended the deceased from September, 1960 A.M. to 10-10, 1961, that (I) (we) last saw the deceased alive on 10/10/ 1961, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Yasuo Takahashi M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 10-10-61

22c. PHYSICIAN'S NAME (Type): Yasuo Takahashi, M.D.

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-13-1961

23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

23d. LOCATION (City, town, or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Bailey's Funeral Home — ADDRESS: Frederick, Md.

25a. REC'D BY REGISTRAR DATE: OCT 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11231 — Reg. Dist. No. 11220

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: VISITING
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 104 ANCHOR ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST MINSTER ROUTE #4
d. STREET ADDRESS: Manchester Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First EBNEST — Middle HARBAUGH — Last BELL
4. DATE OF DEATH: Month OCTOBER — Day 16 — Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 9 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George A. Bell
14. MOTHER'S MAIDEN NAME: Ida V.C. Harbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes — If yes, give war or dates of service: World War I
16. SOCIAL SECURITY NO.: 212-32-3762
17. INFORMANT — Address: Mrs Beulah M. Bell, Westminster, Md RD#4

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 5 MINUTES
DUE TO
(b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 1 YEAR.
DUE TO
(c):

420.1

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUGUST, 1960, to OCTOBER 1961, that I last saw the deceased alive on OCTOBER 16, 1961, and that death occurred at 10 34 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel I Welliver M.D. — ADDRESS (Street, city or town, state): 19 RIDGE ROAD — DATE SIGNED: 10/16/61

PHYSICIAN'S NAME (Type): DANIEL I WELLIVER — WESTMINSTER MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/19/61
22c. NAME OF CEMETERY OR CREMATORY: Leisters Church Cemtery
22d. LOCATION (City, town, or county) (State): Road, Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. S. Myers Jr. — ADDRESS: Westminster, Md

24a. RECD. BY REGISTRAR DATE: 10 19 61
24b. REGISTRAR'S SIGNATURE: Clifford S. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11232

CERTIFICATE OF DEATH

11221

1. **PLACE OF DEATH** a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 27 N MAIN ST

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X HAMPSTEAD Maryland
d. STREET ADDRESS: 127 N. MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARY Middle: Margaret Last: BERRY

4. **DATE OF DEATH**: Month: October Day: 14 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 26 1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home.

11. BIRTHPLACE (State or foreign country): KANSAS

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Henry Holecamp.

14. MOTHER'S MAIDEN NAME: Christina Kelly.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Fredrick BERRY Address: HAMPSTEAD Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Arteriosclerotic Cardiovascular disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from August 6, 1956 to October 14, 1961, that (I) (we) last saw the deceased alive on Oct 14 1961 and that death occurred at 3 AM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-15-61

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 17-1961

23c. NAME OF CEMETERY OR CREMATORY: Polk cemetery

23d. LOCATION (City, town, or county) (State): Mifflintown Penna

24. FUNERAL DIRECTOR'S SIGNATURE: Tipton-Eline — ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE: OCT 18 61

25b. REGISTRAR'S SIGNATURE: Cathryn L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11233 11222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 1yr. 2 mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto.City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24
   d. STREET ADDRESS: 3407 E. Fayette St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Otto — Middle: — Last: Boettger

4. **DATE OF DEATH**: October 20, 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 1, 1888

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brewer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Biettger

14. MOTHER'S MAIDEN NAME: Marie Pieas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

422

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction. Pulmonary tuberculosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

002X

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 22, 1960, to October 20, 1961, that (I) (we) last saw the deceased alive on October 19, 1961, and that death occured at 7:00 AM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/20/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: Oct. 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

23d. LOCATION (City, town or county) (State): Parkville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ullric h Funeral Home, Baltimore, Md.

25a. REC'D BY REGISTRAR — DATE: OCT 24 '61

25b. REGISTRAR'S SIGNATURE: Cathryn S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11234 — 11223

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 57 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Federalsburg~~ Md.
b. COUNTY: Caroline ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): General Delivery
d. STREET ADDRESS: General Delivery, Federalsburg,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Floyd — Middle: — Last: Bost

4. DATE OF DEATH: Month: October — Day: 21 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9, 1914

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: No record

11. BIRTHPLACE (County & State, or foreign country): Concord, North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Bost

14. MOTHER'S MAIDEN NAME: Molly Bost

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 198-07-9788

17. INFORMANT: Leonard Bost — Address: 4910 Hooper St., Phila. Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far adv. bilat. pulm. tbc., Cavitation. — INTERVAL BETWEEN ONSET AND DEATH
002X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovalcular disease. Myocardial infarction.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-24-61, 19..., to 10-21, 19 61 that (I) (we) last saw the deceased alive on October 21 19 61, and that death occured at 4:27 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans., MD

22d. ADDRESS: Henryton State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 25, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

23d. LOCATION (City, town or county) (State): Bethlehem, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. J. Framptom and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11235 Item 1c Film C-88 10/25/61 jd 11224

1. PLACE OF DEATH

a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 2 months 13 dys.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland

b. COUNTY: Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. STREET ADDRESS: 70 Murdock Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sebastian — Middle: John — Last: Brauer

4. DATE OF DEATH: Month: October — Dey: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 22, 1884

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: — Deys: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper -retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David Brauer

14. MOTHER'S MAIDEN NAME: Katherine Hook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No —

16. SOCIAL SECURITY NO.: 215-05-9404

17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C. V. D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 31, 1961 to October 14 1961, that (I) (we) last saw the deceased alive on October 14 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Mae D. Brynkmod M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-14-61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-18-61

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tschudy & Sons

ADDRESS: Balto. 17, Md.

25a. REC'D BY REGISTRAR DATE: OCT 16 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11236

Reg. Dist. No. 11225

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Manchester
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bachmans Valley Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Manchester RD#1 Md
d. STREET ADDRESS: Bachmans Valley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle STRUTH Last BREHM

4. DATE OF DEATH: Month OCTOBER Day 27 Year 1961

5. SEX: White
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NV. 14 1887
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Brehm
14. MOTHER'S MAIDEN NAME: Charlotte Fickel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —

INFORMANT: Mrs. Melvin S. Burnhart Address: RD#1 Manchester, Md

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Days

420.1

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1948 to Oct 24, 1961 that I last saw the deceased alive on Oct 24, 1961, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis J Restak M.D. ADDRESS (Street, city or town, state): 226 Frederick St Hanover Pa DATE SIGNED: 10-28-61

PHYSICIAN'S NAME (Type): LEWIS J RESTAK MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/30/61
22c. NAME OF CEMETERY OR CREMATORY: Lesters Church Cemetery
22d. LOCATION (City, town, or county) (State): Rural Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: OCT 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11237 — Reg. Dist. No. 11226

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr. 4 mo.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Westminster
d. STREET ADDRESS: 225 E. Main St., Westminster
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Bell — Last: Brown

4. DATE OF DEATH: Month: 10 — Day: 21 — Year: 1961

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-14-86

9. AGE (In years lost birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joseph Brown
14. MOTHER'S MAIDEN NAME: Caroline Arrington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-26-6565
INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 33/X
(b) Generalized Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis with
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) psychotic reactio
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-29- 1960, to 10-21- 1961, that I last saw the deceased alive on 10-21- 1961, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ilse Kamm M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED:

PHYSICIAN'S NAME (Type): Ilse Kamm M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-23-61
22c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
22d. LOCATION (City, town, or county) (State): Sykesville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: OCT 24 '61
24b. REGISTRAR'S SIGNATURE: Esther L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11238 11227

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 3,191 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 906 Whatcoat Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

003

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Edgar — Last: Brown

4. DATE OF DEATH: Month: October — Day: 9 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-28-1888
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hospital attendent
10b. KIND OF BUSINESS OR INDUSTRY: Henryton St. Hos.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Brown
14. MOTHER'S MAIDEN NAME: Alice Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Joseph E. Brown - Patient — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured aneurysm of abdominal aorta
002x
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Far adv. bilat. pulm. tbc. with cavity left

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 13 1953, to Oct. 9 1961, that (I) (we) last saw the deceased alive on Oct. 9 1961, and that death occurred at 2:55 a.m. M, from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 10-9-61
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.
22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-12-61
23c. NAME OF CEMETERY OR CREMATORY: St. Lukes Methodist
23d. LOCATION (City, town, or county) (State): Riesterstown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Charles R. Law - 802 Madison Ave
25a. REC'D BY REGISTRAR DATE: OCT 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11239 11228

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

M

I

815

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr. 27 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towson
d. STREET ADDRESS: 7604 Far Hills Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03X-2

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Lola	Edith	Buell		10	10	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	white		7/13/79	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edison S. Beane	Jane Bentley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none	none	S. S. Hospital records	Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — 420.0 — Days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Arteriosclerotic heart disease — Years
DUE TO
(c): Arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour	o. m. / p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 9/13/ 1960 to 10/10/ 1961, that ☒ (we) last saw the deceased alive on 10/10/ 1961, and that death occurred at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal, M.D. — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	Oct. 13, 1961	Woodlawn Cemetery	Woodlawn, Balto. Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John Burns Sons — ADDRESS: Towson, Md.

25a. REC'D BY REGISTRAR: DATE OCT 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11240 — 11229

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural, Westminster, RD #2
d. STREET ADDRESS: Off. Pleasant Valley Road
a. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: DAVID — Middle: EARL — Last: BYERS

4. DATE OF DEATH: Month: OCT. — Day: 20 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 4, 1918
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David E. Byers
14. MOTHER'S MAIDEN NAME: Helen Schaeffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Pauline M. Byers — Address: Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs
DUE TO (b): Coronary occlusion — 5 hrs
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 20, 1961, to Oct 20, 1961, that (I) (we) last saw the deceased alive on Oct 20 1961, and that death occured at 9:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. Chepko — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/20/61
22c. PHYSICIAN'S NAME (Type): J. Chepko
22d. ADDRESS: 85½ W. Green St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 10/23/61 — 23c. NAME OF CEMETERY OR CREMATORY: Kruders Cemetery — 23d. LOCATION (City, town or county) (State): Rural Westminster, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr., Westminster, Md — ADDRESS —

25a. REC'D BY REGISTRAR DATE: OCT 24 '61 — 25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11241 — 11230

1. PLACE OF DEATH — a. COUNTY: CARROLL — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MD. — b. COUNTY: P.G. ✓

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WOODBINE, MD RURAL — c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UPPER MARLBORO MD.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GOLDEN AGE CONV. HOME — d. STREET ADDRESS: 16X-1 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLARD — Middle: HENRY — Last: CHAPMAN

4. DATE OF DEATH: Month: OCT. — Day: 16 — Year: 1961

5. SEX: M — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: MARCH 25, 1871 — 9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER — 10b. KIND OF BUSINESS OR INDUSTRY: Self — 11. BIRTHPLACE (State or foreign country): Iowa — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY CHAPMAN — 14. MOTHER'S MAIDEN NAME: Amelia Wrought

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT — Address: MYRA TALBOTT, W

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

Conditians, if any, which gove rise to immediate couse (a), stating the underlying couse lost.

DUE TO (b): Art. Arterio Sclerosis — 10 yrs

DUE TO (c): Hypertension — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Manth, Day, Year 19 — 20d. INJURY OCCURRED While at wark ☐ Nat while at wark ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] M. from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): MARKELL MARTIN — 22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE THEREOF: 10/18/61 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — 23d. LOCATION (City, town, or county): Colmar Manor, — (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Francis Gasch's Sons Hyattsville, Maryland — 25a. REC'D BY REGISTRAR DATE: OCT 19 '61 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11242 — Reg. Dist. No. 11231

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taylorsville
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. D. 2, Mt. Airy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taylorsville
d. STREET ADDRESS: R. D. 2, Mt. Airy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DASIY 15 — Middle D. — Last CONDON

4. DATE OF DEATH: Month October — Day 11, — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 3, 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: George Bair
14. MOTHER'S MAIDEN NAME: Annie Rigler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ********** **********
16. SOCIAL SECURITY NO.: **********
17. INFORMANT: Mrs. Evelyn Franklin, R. D. 2, Mt. Airy, Address Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio Sclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-2-, 1961, to 10-12-, 1961, that I last saw the deceased alive on 10-11, 1961, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T Marsh, M.D. — ADDRESS (Street, city or town, state): WESTMINSTER MD — DATE SIGNED: 10-12-61

PHYSICIAN'S NAME (Type): JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-14-1961
22c. NAME OF CEMETERY OR CREMATORY: Taylorsville Cemetery
22d. LOCATION (City, town, or county) (State): Taylorsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. WALTZ, WINFIELD, MARYLAND
24a. REC'D BY REGISTRAR DATE: OCT 16 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11243

CERTIFICATE OF DEATH

11232

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 16 — 3V014
d. STREET ADDRESS: 3501 Winterbourne Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Baxter — Last: Davis

4. DATE OF DEATH: Month: October — Day: 1, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 8, 1888

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pensioned

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mary Ann [illegible]?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

49K

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. with cerebral arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from September 23, 1961 to October 1, 1961 that (I) (we) last saw the deceased alive on October 1, 1961, and that death occured at 4:30PM from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/1/61

22c. PHYSICIAN'S NAME (Type): Naci Buyukunsal, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-4-61

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.

23d. LOCATION (City, town or county) (State): Pikesville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Tucker & Son

ADDRESS: W. Baltimore, Balto.

25a. REC'D BY REGISTRAR — DATE OCT 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11244 Item 1c Film G290 10/26/61 iwk Item 4 Film G300 11/1/61 mh 11233

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 8 months-27 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
d. STREET ADDRESS: 21X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle; Middle: Gaynelle; Last: FINK
4. DATE OF DEATH: Month: 10; Day: 8, 7; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-3-92
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Burnett
14. MOTHER'S MAIDEN NAME: Josephine Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (b): Generalized arteriosclerosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. Epileptic seizures.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour; a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 1-10 1961, to 10-7- 1961, that ☒ (we) last saw the deceased alive on 10-7- 1961, and that death occurred at 10.55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Agustin del Campo.M.D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: 10.11.61
23c. NAME OF CEMETERY OR CREMATORY: St Peters Catholic
23d. LOCATION (City, town, or county) (State): Hancock Washington Md

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K Stone Hancock Md
ADDRESS:
25a. RECD BY REGISTRAR DATE: OCT 13 '61
25b. REGISTRAR'S SIGNATURE: Charles E. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11245 11234

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 4 y. 10 m. 20d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 87 Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

015

3. NAME OF DECEASED (Type or print): First: Cora; Middle: Belinda; Last: Fitze
4. DATE OF DEATH: Month: 10; Day: 9; Year: 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/22/74
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ezra Wantz
14. MOTHER'S MAIDEN NAME: Belinda Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: S. S. Hosp. records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: Years.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis. — Years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 11/19 1956 to 10/9 19 61, that ☒ (we) last saw the deceased alive on 10/9 1961, and that death occurred at 2:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Naci R. Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/9/61
22c. PHYSICIAN'S NAME (Type): Naci Buyukunsal, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/12/61
23c. NAME OF CEMETERY OR CREMATORY: Kruder's Cemetery
23d. LOCATION (City, town, or county) (State): Westminster, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr.
ADDRESS: Westminster, Md.
25a. RECD BY REGISTRAR DATE: OCT 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11246

CERTIFICATE OF DEATH

11235

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 2yrs. 2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (24)
d. STREET ADDRESS: 1901 S. Newkirk Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Isabelle — Last: FRIEDEL

4. DATE OF DEATH: Month: OCTOBER — Day: 18 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-19-97

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR — Months: — Days: —
IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Ketchun

14. MOTHER'S MAIDEN NAME: Rose Horne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: months
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS associated with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 10-16 19 59, to 10-18 19 61, that ☒ (we) last saw the deceased alive on 10-18 19 61 and that death occurred at 9:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Ilse Kamm M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10-19-61

22c. PHYSICIAN'S NAME (Type): Ilse Kamm, M. D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-21-1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
23d. LOCATION (City, town, or county) (State): O'Donnell St. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: JOHN J. DUDA 2829 Hudson St. 24, Md.

25a. REC'D BY REGISTRAR DATE: OCT 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11247

CERTIFICATE OF DEATH

11236

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A1S (4)
1SM 9/60

1. PLACE OF DEATH

a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 4yrs.4mos.25dys

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)

a. STATE: Maryland

b. COUNTY: Balto. City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18

3V 01-4

d. STREET ADDRESS: 612 Montpelier Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	George	Leslie	Garnett		October	19	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED	October 7, 1894	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	-	Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Garnett	Hester Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes 1917-1918	187-03-6975H	Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure due to arteriosclerotic heart disease — Interval between onset and death: Years

002X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Healed milliary pulmonary tuberculosis. — Years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.
C.B.S. with alcohol intox. without qualifying phrase. Pulmonary T.B.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. **I certify** that (I) (this hospital) attended the deceased from 5-24-, 19 57 to 10-19-, 19 61, that (I) (we) last saw the deceased alive on 10-19-, 19 61, and that death occured at 6:50 P.m. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Julian Radzykewycz M.D.		10-19-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Julian Radzykewycz, M.D.	Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	10-23-61	Baltimore National	Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street	OCT 24 '61	Clifton L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11248 11237

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 yrs 16 dys
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, Md
d. STREET ADDRESS: 102 Argyle St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15X-2

3. NAME OF DECEASED (Type or print): First: Edith Middle: S Last: Gray

4. DATE OF DEATH: Month: Oct Day: 14 Year: 1961

5. SEX: Female
6. COLOR OR RACE: Wh
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-11-1890
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Stearns
14. MOTHER'S MAIDEN NAME: Emily Palmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Sprigfield State Hospital Records — Address: Sykesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subacute vegetation bacterial endocarditis, — INTERVAL BETWEEN ONSET AND DEATH: weeks

430X

DUE TO (b): organism unknown.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): left lung - Bronchopneumonia. Bronchostaxis with abscess formation in lower — weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, depressed type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I (this hospital) attended the deceased from 8-28-1957 19___ to 10-14- 19 61 that (I) (we) last saw the deceased alive on 10-14- 19 61, and that death occurred at 8. AM, from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsol M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/14/61
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsol, M.D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 10/16/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 19 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11249

12159

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 3y.5m.29d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 205 E. North Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

015

3. NAME OF DECEASED (Type or print): First: Edna; Middle: ; Last: Hall

4. DATE OF DEATH: Month: 10; Day: 31; Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/6/87

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

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13. FATHER'S NAME: Luther H. Galway

14. MOTHER'S MAIDEN NAME: Langley ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, depressed type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 5/2/ 1958 to 10/31 1961, that ☒ (we) last saw the deceased alive on 10/31 1961, and that death occurred at 11:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Rita S. Glahn M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/1/61

22c. PHYSICIAN'S NAME (Type): Rita S. Glahn, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-7-61

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Haight

ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: NOV 9 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11250 — 11238

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 2 — 3V01-4
d. STREET ADDRESS: 125 Cheapside
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rudolph — Middle: Carl George — Last: Jantzen

4. DATE OF DEATH: Month: October — Day: 5, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: May 21, 1913

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thies Jantzen

14. MOTHER'S MAIDEN NAME: Matilda Jensen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Squamous cell carcinoma of the lung with metastasis. — INTERVAL BETWEEN ONSET AND DEATH: Months

163X

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): C.B.S., alcohol intoxication without qualifying phrase. Pulmonary tuberculosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 22, 1959 October 5, 1961 that (I) (we) last saw the deceased alive on October 5, 1961, and that death occured 10:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/5/61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) — **23b. DATE THEREOF**: 10-9-61 — **23c. NAME OF CEMETERY OR CREMATORY**: Loyal Memorial Gardens — **23d. LOCATION** (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Frank H Mauer — **ADDRESS**: Pikesville 8 Md

25a. REC'D BY REGISTRAR DATE: OCT 13 '61 — **25b. REGISTRAR'S SIGNATURE**: Arthur S Flynn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11251 — 11239

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 1,793 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 302 E. Lanvale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Belle — Last: Jones

4. DATE OF DEATH: Month: 10 — Day: 2 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-14-1918

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wilmington, N.C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Jones

14. MOTHER'S MAIDEN NAME: Darlene Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Clara B. Jones - Patient
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far advanced bilateral cavitary pulmonary TB
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 5, 1956 to Oct. 2, 1961 that (I) (we) last saw the deceased alive on Oct. 2, 1961, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-2-61

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M.D., Supt.
22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 6, 1961
23c. NAME OF CEMETERY OR CREMATORY: Balto Nat Ce.
23d. LOCATION (City, town, or county) (State): 5301 Frederick Ave. Balto, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph L Russ
ADDRESS: 2222 W North Ave

25a. REC'D BY REGISTRAR DATE: OCT 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11252 11240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. **PLACE OF DEATH** a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr. 11mo. 19d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 01 02-2
d. STREET ADDRESS: 155 Bedford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Agnes Middle: Lucretia Last: Keller

4. **DATE OF DEATH**: Month: October Day: 28 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 28 1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Slaughter

14. MOTHER'S MAIDEN NAME: Mahala A. Slaughter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-12-2200

17. **INFORMANT** Address: Hospital Record Springfield St. Hosp.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Insufficiency.
INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Brain Syndrome Associated
DUE TO (c): Senile Brain Disease with Psychotic Reaction

204X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-9-6-30 1959 to Oct. 28, 1961 that (I) (we) last saw the deceased alive on Oct. 28 1961, and that death occurred at p.M, from the causes and on the date stated above.

22a. SIGNATURE: Paul A. Bryan M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/28/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/31/61
23c. NAME OF CEMETERY OR CREMATORY: Rosedale
23d. LOCATION (City, town, or county) (State): Martinsburg, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard L. Brown
ADDRESS: Martinsburg, W. Va.

25a. REC'D BY REGISTRAR DATE: OCT 31 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Hawse

VR A1S (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12170

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9yrs.9mos.1day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2130 Callow Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 V01-4

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	Randolph	Kennerly	October	30,	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		October 15, 1891	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Kennerly	Sara English

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give were or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	216-12-1710	Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute myocardial infarction	Minutes
420-1 DUE TO (b)	Coronary arteriosclerosis	Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia, paranoid type, with alcoholism, and asocial behavior.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
-	- 19					

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/30/61

EXAMINER'S NAME (Type): James T. Marsh, M.D.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	11-1-61	MARDELA	MARDELA, MD

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
SMITH FUNERAL HOME, SHARPTOWN, MD	NOV 9 '61	Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11254 11241

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
c. LENGTH OF STAY IN 1b: 16 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cedarhurst Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg Rural
d. STREET ADDRESS: Cedarhurst Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Howard — Last: Kerr

4. DATE OF DEATH: Month: October — Day: 26 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 25 1907

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: State Road.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Karl Kerr

14. MOTHER'S MAIDEN NAME: Lucille Chilcoat.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 216-10-8051

17. INFORMANT: Gladys Minnie Kerr — Address: Finksburg Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 27, 1961, to Oct 26, 1961, that (I) (we) last saw the deceased alive on 10-12 1961, and that death occured at 7:24 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 30, 1961

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Gardens

23d. LOCATION (City, town or county) (State): Finksburg Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Henry James Eckhardt Owings Mills, Md.

25a. REC'D BY REGISTRAR DATE: OCT 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11255 11242

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville
c. LENGTH OF STAY IN THIS PLACE: 40 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville
d. STREET ADDRESS: Marriottsville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda Middle: Eleanor Last: Kidd

4. DATE OF DEATH: Month: October Day: 4 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 21, 1898
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Springfield Hospital
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Duvall
14. MOTHER'S MAIDEN NAME: Sallie Dawner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 219-36-2164
17. INFORMANT: Mr Wm B. Kidd - above Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure, Anemia, Acute metrhorrhagia — INTERVAL BETWEEN ONSET AND DEATH: 1960
DUE TO (b): Carcinoma breast & Generalized metastasis — TO
DUE TO (c): Lung, liver, CNS. — 1961

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Nat while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (Caunty) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 1960, 19___, to 1961, 19___, that (I) (we) last saw the deceased alive on 4 Oct 1961, and that death occurred at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5 Oct. 1961
22c. PHYSICIAN'S NAME (Type): HOWARD E. HALL
22d. ADDRESS: SYKESVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-6-61
23c. NAME OF CEMETERY OR CREMATORY: Springfield.
23d. LOCATION (City, town, or county) (Stote): Sykesville Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Haight
ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11256 — 11243

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4mos.24days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 5 3V01-4
d. STREET ADDRESS: 528 N. Clinton St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Leonard — Last: Krauss

4. DATE OF DEATH: Month: October — Day: 25, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 28, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive engineer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Leonard Krauss

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES 8/12/05 - 6/27/09

16. SOCIAL SECURITY NO.: 717-07-8626

17. INFORMANT — Address: Springfield Hospital Records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Years
420.0
DUE TO
(b): Arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction. Alcoholism.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1, 1961, to October 25, 1961 that (I) (we) last saw the deceased alive on October 24, 1961, and that death occured at 10/25/61 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/25/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/27/61

23c. NAME OF CEMETERY OR CREMATORY: BALTO. NAT. CEM

23d. LOCATION (City, town or county) (State): BALTO., MD.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hartley Miller, 2334 Jefferson St.

25a. REC'D BY REGISTRAR DATE: OCT 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11257

CERTIFICATE OF DEATH

11244

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Long View Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenmount
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GERTRUDE — Middle A — Last LEISTER

4. DATE OF DEATH: Month Oct — Day 23 — Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Aug 3 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph H Lippy

14. MOTHER'S MAIDEN NAME: Martha A Neal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Laurence Leister, Manchester Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

DUE TO (b): 4221 arterio sclerosis - C-V. Disease — 15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of hip - 6 mo, Ca of colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 1961, to 10-23, 1961, that (I) (we) last saw the deceased alive on 10-22, 1961, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M.C. Porterfield M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-23-61

22c. PHYSICIAN'S NAME (Type): M.C.Porterfield

22d. ADDRESS: Hampstead Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 26/61

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION (City, town or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Clipton-Eline

ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE OCT 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krouse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11258

CERTIFICATE OF DEATH

11245

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City (Prince Georges)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 4316 Newton Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1644-2

3. **NAME OF DECEASED** (Type or print): First: Eliza; Middle: Deaville; Last: Lowery

4. **DATE OF DEATH**: Month: October; Day: 23; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 13, 1884

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Cleaner

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Deaville

14. MOTHER'S MAIDEN NAME: Eleanor Dougall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT Address: Springfield State Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. with cerebral arteriosclerosis without qualifying phrase. Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-25- 19 61 to 10-23- 19 61, that (I) (we) last saw the deceased alive on 10-23- 1961, and that death occured at 6:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-24-61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 27, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Colmar Manor Md.

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville Md.

25a. REC'D BY REGISTRAR DATE: OCT 30 '61

25b. REGISTRAR'S SIGNATURE: Curtiss L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11259 **CERTIFICATE OF DEATH** 11246

Item 1c Film G298 10/25/61 iwk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY	Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Sykesville
c. LENGTH OF STAY IN 1b	23 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Springfield State Hospital
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE	Maryland
b. COUNTY	Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rockville
d. STREET ADDRESS	13221 Fox Den Drive
e. IS RESIDENCE ON A FARM?	YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First / Middle / Last	Fannie Lillian Young Madigan
4. DATE OF DEATH Month / Day / Year	October 14 1961
5. SEX	Female
6. COLOR OR RACE	White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
8. DATE OF BIRTH	February 8, 1886
9. AGE (In years last birthday)	75 yrs.
IF UNDER 1 YEAR Months / Days	
IF UNDER 24 HRS. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housewife
10b. KIND OF BUSINESS OR INDUSTRY	-
11. BIRTHPLACE (County & State, or foreign country)	Maryland
12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Luther Young
14. MOTHER'S MAIDEN NAME	Sarah Young
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	No -
16. SOCIAL SECURITY NO.	-
17. INFORMANT Address	Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Renal failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic C. V. D.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 21, 19 61 to 10-14-61, 19, that (I) (we) last saw the deceased alive on 10-14-61 19, and that death occured at 7A M, from the causes and on the date stated above.

22a. SIGNATURE Agustin del Campo. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Agustin delCampo, M.D.

22d. ADDRESS Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	10/16/61	Methodist Church Cemetery	Damascuss, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Avenue Rockville, Md.

25a. REC'D BY REGISTRAR DATE OCT 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11260

CERTIFICATE OF DEATH

Reg. Dist. No. 11247

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Sykesville RD #3
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Sykesville RD #3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Belle; Lost: Maus

4. DATE OF DEATH: Month: October; Day: 2; Yeor: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 25, 1900

9. AGE (In yeors lost birthdoy): 60 yrs.

IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS.: Hours; Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rehabilitation worker

10b. KIND OF BUSINESS OR INDUSTRY: Rosewood Training Sch.

11. BIRTHPLACE (Stote or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. Bernard Ecker

14. MOTHER'S MAIDEN NAME: M. Kate Koontz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ----- (If yes, give wor or dates of service): -------

16. SOCIAL SECURITY NO.: 218-32-8039

INFORMANT: John S. Maus — Address: Sykesville RD #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary thrombosis, Cardiac failure, — INTERVAL BETWEEN ONSET AND DEATH: 1960
DUE TO (b): Old Hemorrhagic Cerebral Lesion, — INTERVAL BETWEEN ONSET AND DEATH: to
DUE TO (c): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 1961

4201
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify thot I attended the deceased from 1960, 19___, to 1961, 19___, that I lost sow the deceased olive on 2 Oct, 1961, and that death occurred at 12 noon M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E Hall M.D.

ADDRESS (Street, city or town, stote): Sykesville, Md

DATE SIGNED: 2 Oct 61

PHYSICIAN'S NAME (Type)

22o. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Oct. 4, 1961

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or county) (Stote): Silver Run Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. E. Myers Jr., Westminster, Md.

24a. REC'D BY REGISTRAR DATE: OCT 4 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11261

CERTIFICATE OF DEATH

11248

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg, RD #1
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg, RD #1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print): First: Julius — Middle: Brinkley — Last: Maynard

4. DATE OF DEATH: Month: October — Day: 17 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 11, 1888

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired store manager

10b. KIND OF BUSINESS OR INDUSTRY: retail

11. BIRTHPLACE (State or foreign country): Morrisville, N. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Brinkley Maynard

14. MOTHER'S MAIDEN NAME: Yancey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - -
(If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: 230-14-5514

INFORMANT — Address: Mrs. Blanche G. Maynard, Finksburg, RD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: few minutes

420.1

DUE TO
(b): Coronary Insufficency — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): General Arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1-1950, to 10-17-61, that I last saw the deceased alive on 10-16-61, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James G. Saffell M.D. — ADDRESS (Street, City or town, state): Reisterstown Md — DATE SIGNED: 10-18-61

PHYSICIAN'S NAME (Type): James G. Saffell MD — Reisterstown, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Oct. 20, 1961

22c. NAME OF CEMETERY OR CREMATORY: Providence Cemetery

22d. LOCATION (City, town, or county) (State): Finksburg RD # 1 Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR: DATE OCT 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11262

CERTIFICATE OF DEATH

1249

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester Rural
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: LYDIA — Middle: M — Last: McINTYRE

4. DATE OF DEATH: Month: Oct — Day: 8 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: 8-18-1876

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Nurse

11. BIRTHPLACE (County & State, or foreign country): N Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Letterman

14. MOTHER'S MAIDEN NAME: Louise Riddle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT Address: Family Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 30, 19 57 to Oct 8, 1961, that (I) (we) last saw the deceased alive on Sept 18 1961, and that death occured at 8 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 10-9-61

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 10/61

23c. NAME OF CEMETERY OR CREMATORY: Sunset

23d. LOCATION (City, town or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Tipton - Elsie

ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE: OCT 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11263

CERTIFICATE OF DEATH

11250

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 5 yrs

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: P. — Last: MILLER
4. DATE OF DEATH: Month: Oct — Day: 9 — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 25 1899
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Canning
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H Miller
14. MOTHER'S MAIDEN NAME: Virginia A Redding

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: 216-14-0424
17. INFORMANT: Mrs W P. Miller — Address: Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Bronchitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1957 to Oct 9, 1961, that (I) (we) last saw the deceased alive on Oct 9 1961, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: /
22c. PHYSICIAN'S NAME (Type): W H Foard MD
22d. ADDRESS: Manchester, Md — 10-9-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 12-61
23c. NAME OF CEMETERY OR CREMATORY: Free Methodist
23d. LOCATION (City, town or county) (State): Alesia - Carroll Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Tipton - Elsie - Hampstead Md
ADDRESS
25a. REC'D BY REGISTRAR DATE: OCT 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11264

CERTIFICATE OF DEATH

11251

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 8 months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster
   d. STREET ADDRESS: 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle — Last: Mitchell

4. **DATE OF DEATH**: Month: 10 — Day: 25 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/25/61

9. AGE (In years last birthdey) yrs. — IF UNDER 1 YEAR: Months — Deys — IF UNDER 24 HRS.: Hours — Min. 20

10a. USUAL OCCUPATION (Give kind of work dona during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & Slete, or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Charles Mitchell

14. MOTHER'S MAIDEN NAME: Sally Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: —

17. **INFORMANT**: Charles E. Mitchell — Address: Westminster Md RD #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one ceuse per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 15 or 20 min.

759.3

DUE TO (b): Congenital atresia trachea — Congenital.

Conditions, if any, which gave rise to immedieta ceuse (a), stating the underlying ceuse lest. DUE TO (c): Old infarct of placenta — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/25 1961, to 10/25, 1961, that (I) (we) last saw the deceased alive on 10/25 19 61, and that death occured 4:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J Chepko M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED 10/25/61

22c. PHYSICIAN'S NAME (Type): Julius Chepko

22d. ADDRESS: 85½ W. Green St. Westminster, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 10/26/61 — 23c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery — 23d. LOCATION (City, town or county) (Stete): Rural, Westminster, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

25e. REC'D BY REGISTRAR DATE OCT 31 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

2068212 X V 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11265 11252

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 9 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

d. STREET ADDRESS: 306 N. Parrish Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 V 01-4

003

3. NAME OF DECEASED (Type or print): First Walker; Middle; Last Mitchell

4. DATE OF DEATH: Month 10; Day 19; Year 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/18/1887

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lynchburg Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Walter Mitchell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Walker Mitchell - Patient
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far advanced bilateral cavitary pulmonary TB
0 0 2 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1961, to Oct. 19, 1961 that (I) (we) last saw the deceased alive on Oct. 19 1961, and that death occurred at 8:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-19-61

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M.D.

22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 23 1961

23c. NAME OF CEMETERY OR CREMATORY: W. H. Cadwalader Cem

23d. LOCATION (City, town, or county): Baltimore (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R. Williams

ADDRESS: 322 N. Howard St

25a. REC'D BY REGISTRAR DATE: OCT 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11266 Item 14 Film G299 11/3/61 iwk 11253

1

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 mos. 6 dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 4
d. STREET ADDRESS: 1737 Redwood Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03X-2

015

3. NAME OF DECEASED (Type or print): First: Sophie; Middle: Mollie; Last: Mueller

4. DATE OF DEATH: Month: October; Day: 27; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1886

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Monk

14. MOTHER'S MAIDEN NAME: Caroline unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4200

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.?

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-21-, 1961, to 10-27-, 1961, that (I) (we) last saw the deceased alive on 10-27-1961, and that death occured at 8:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-27-61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10-30-61

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. Cook, Inc., 1217 St. Paul Street, Baltimore — ADDRESS

25a. REC'D BY REGISTRAR DATE: OCT 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11267 — Reg. Dist. No. 11254

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
d. STREET ADDRESS: 14 Gist Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROBERT Middle M. Last MYERLY

4. DATE OF DEATH: Month OCT. Day 16 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 2, 1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paint Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Color Craft Corp.
11. BIRTHPLACE (State or foreign country): Westminster Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Milton Myerly
14. MOTHER'S MAIDEN NAME: Sallie Whitmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-7343

INFORMANT: Mrs Robt. M. Myerly — Address: Same address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Abdominal Aortic Aneurysm.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs.

451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 16, 1961, to Oct 16, 1961, that I last saw the deceased alive on Oct 16, 1961, and that death occurred at 5:45 P.M. from the causes and an the date stated abave.

ACTUAL SIGNATURE: Richard Y. Dalrymple M.D. — M.D. — ADDRESS (Street, city or town, state): 265 Gait Place — DATE SIGNED: 10-16-61

PHYSICIAN'S NAME (Type): Richard Y. Dalrymple M.D. — Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/19/61
22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery
22d. LOCATION (City, town, or county) (State): Rural Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md

24a. REC'D BY REGISTRAR DATE: OCT 19 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11263 — 11255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 6yrs.6mos.5days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto.City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18 — 3V01-4
   d. STREET ADDRESS: 2218 N. Calvert St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ruth — Middle: Elizabeth — Last: Streett — Parker

4. **DATE OF DEATH**: Month: October — Day: 18, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1887

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William A. Streett

14. MOTHER'S MAIDEN NAME: Martha McAtee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No / -

16. SOCIAL SECURITY NO.: 215-34-7627

17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent cardiovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Days
443X
DUE TO (b): Hypertensive arteriosclerotic cardiovascular disease. — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.assoc.with circulatory disturbance with cerebral arteriosclerosis without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 13, 1955, to October 18, 1961, that (I) (we) last saw the deceased alive on October 17, 1961, and that death occured at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/18/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/20/1961

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Henry W. Jenkins & Sons Co., Inc. 4905 York Road Balto. 12;, Md.

25a. REC'D BY REGISTRAR DATE: OCT 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11269 Reg. Dist. No. 11256

1. PLACE OF DEATH
a. COUNTY Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural New Windsor
c. LENGTH OF STAY IN 1b 20 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD#1 Western Chapel

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural New Windsor RD#1
d. STREET ADDRESS Western Chapel
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First DAVID Middle Last PERRY

4. DATE OF DEATH Month October Day 22 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov 9 ?

9. AGE (In years last birthday) 56 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Black & Decker

11. BIRTHPLACE (State or foreign country) Rocky mount N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Levi Perry

14. MOTHER'S MAIDEN NAME Lindey White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 213-05-7190

INFORMANT Mrs Lessie B. Perry, Address Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerosis — 8 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1950, to 10-22-1961, that I last saw the deceased alive on Oct 20, 1961, and that death occurred at 4:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE E Reese Wilkens M.D. ADDRESS (Street, city or town, state) 15 Kenders ave DATE SIGNED 10/23/61

PHYSICIAN'S NAME (Type) E Reese Wilkens Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10/24/61

22c. NAME OF CEMETERY OR CREMATORY Western Chapel Cemetery

22d. LOCATION (City, town, or county) (State) New Windsor RD#1 Md

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. ADDRESS Westminster, Md.

24a. REC'D BY REGISTRAR DATE OCT 24 '61

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11270

CERTIFICATE OF DEATH

11257

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 50yrs.9mos.17dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Osborn		Ridgely	October	25	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		1880	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm hand	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles M. Ridgely	Sarah R.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Unk. -	-	Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, right lung.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dementia Praecox.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-8-, 1911, to 10-25-, 1961, that (I) (we) last saw the deceased alive on 10-25-1961, and that death occured at 10:45 a.m. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Agustin del Campo M.D.		10-25-61
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	22d. ADDRESS Springfield State Hospital, Sykesville, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. ~~NAME OF CEMETERY OR CREMATORY~~	23d. LOCATION (City, town or county) (State)
	10-27-61	Mt. Olivet Memorial Park	Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Frank H Pennell	Pikesville Md	OCT 31 '61	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11271 — 11258

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Winfield Rural--Sykesville 2,
c. LENGTH OF STAY IN 1b: 60 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Winfield Rural-- P. O. Sykesville R. D. 2
d. STREET ADDRESS: Arthur Shipley Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Arthur Shipley Road

3. NAME OF DECEASED (Type or print): First ANDIE Middle JANE Last SHIPLEY

4. DATE OF DEATH: Month October Day 9, Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: January 1, 1867
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Brice Shipley
14. MOTHER'S MAIDEN NAME: Mary Jane Buckingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Arthur Shipley, Address: Arthur Shipley Rd. Sykesville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure, Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1960 to 1961

DUE TO (b): Arteriosclerosis Generalized, Senility

DUE TO (c): Chronic Urinary Syndrom

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 19__ to 9 Oct 1961, that (I) (we) last saw the deceased alive on 9 Oct 1961, and that death occurred at 1:P M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 10 Oct 61
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-12-1961
23c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
23d. LOCATION (City, town, or county) (State): Westminster, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 13 '61
25b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11272

CERTIFICATE OF DEATH

11259

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Woodbine
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Hoods Mill Road R. D. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Woodbine
d. STREET ADDRESS: Hoods Mill Road, R. D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NANNIE Middle B. Last SHOEMAKER

4. DATE OF DEATH: Month October Day 18, Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 26, 1889
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months . Doys
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Beall Gosnell
14. MOTHER'S MAIDEN NAME: Emily Jane Gartrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. Emily E. Pearre, Woodbine, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis, arteriosclerosis	1959 TO 1961
DUE TO (b)	Hypertension, Arteriosclerotic heart disease	
DUE TO (c)	Immediate.	

420.1

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port-II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19 Sep 59 19__, to 18 Oct 19 61, that (I) (we) last saw the deceased alive on 18 Oct 19 61, and that death occurred at 1030 A M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 19 Oct 61
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-21-1961
23c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel Cemetery
23d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 20 '61
25b. REGISTRAR'S SIGNATURE: William S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11273 11260

1. **PLACE OF DEATH**
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, SYKESVILLE
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SPRINGFIELD STATE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: FREDERICK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SMITHBURG Rural
d. STREET ADDRESS: ROUTE # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: ERNEST Middle: EZRA Last: SMITH

4. **DATE OF DEATH**: Month: 10 Day: 13 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3/11/82

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U. S. A.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Smith

14. MOTHER'S MAIDEN NAME: Ann M. ~~Xxxxxxx~~ Farsht

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --- (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-05-6560

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis
DUE TO
(c): Coronary Insufficiency

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with cerebral arteriosclerosis without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 9 1961, to Oct. 13, 1961, that (I) (we) last saw the deceased alive on Oct. 13 1961, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. V. Houck Jr. M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 10/13/61

22c. PHYSICIAN'S NAME (Type): R. Vance Houck, M.D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct.15,1961
23c. NAME OF CEMETERY OR CREMATORY: Reformed
23d. LOCATION (City, town, or county) (State): Wolfsville,Fred.Co.Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Paul F. Bittle
ADDRESS: Paul F. Bittle, Myersville, Md.

25a. REC'D BY REGISTRAR DATE: OCT 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11274

CERTIFICATE OF DEATH

11261

1. PLACE OF DEATH
e. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission)
e. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Harry — Middle: L. — Last: Stanley

4. DATE OF DEATH: Month: October — Dey: 21 — Yeer: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: July 21,1888

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Deys: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Hurlock, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence Stanley

14. MOTHER'S MAIDEN NAME: Jennie Lake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No Yes — (If yes give war or dates of service): W.W. #1

16. SOCIAL SECURITY NO.: 217-03-4380

17. INFORMANT — Address: India M. Stanley., Rt # 2., Federalsburg, Md

18. CAUSE OF DEATH [Enter only one ceuse per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advanced bilateral Pulmonary TB

DUE TO (b): Malnutrition

Conditions, if eny, which geve rise to immediete cause (a), steting the underlying cause lest. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.)

2Dc. TIME OF INJURY Hour a.m. p.m. — Month, Dey, Yeer 19

2Dd. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, olfice bldg., etc.)

2Df. (City or town) (County) (Stete)

21. I certify that (I) (this hospital) attended the deceased from October 20 1961 to October 21 1961, that (I) (we) last saw the deceased alive on October 21 19 61, and that death occured at 4:00PM from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans

22d. ADDRESS: Henryton State Hospital

23e. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct.25,1961

23c. NAME OF CEMETERY OR CREMATORY: Federal Hill Cemetery

23d. LOCATION (City, town or county) (Stete): Federalsburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.J.Framptom and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11275 — Items 1c & 2 Film 6298 10/25/61 ty — 11262

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3months 22 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City, Maryland
d. STREET ADDRESS: 708 E. 33rd. St. 3 6 1-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Dey	Year
Oliver	Edward	Swift	October	14	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		5-21-1893	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Food Stores	Food Stores	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Luck Swift	Mary Jane ~~Swift~~ O'Connell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give were or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	213-03-4489	Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema
DUE TO (b): Arteriosclerotic C. V. D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized Arteriosclerosis, Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Dey, Yeer 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-22-61, 19..., to 10-14-, 1961, that (I) (we) last saw the deceased alive on 10-14- 1961, and that death occured at 3:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: S. Jaci Jr. Buyukmihci M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Springfield Hospital, Sykesville, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
BURIAL	10/17/61	New CATHEDRAL	BALTIMORE	Md.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E. J. RUCK	5305 HARFord Rd.	OCT 16 '61	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11276

CERTIFICATE OF DEATH

11263

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.6mos.24days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4534 Bennion Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1535-2

3. NAME OF DECEASED (Type or print): First: Hester — Middle: Mabel — Last: Tydd Taylor

4. DATE OF DEATH: Month: October — Day: 18, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: November 1, 1881

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: - Benjamin Tydd

14. MOTHER'S MAIDEN NAME: - Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 106-05-3768

17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a): Old rheumatic heart disease with

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): mitral insufficiency and adhesive peri-

DUE TO (c): carditis.

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 24, 1959, to October 18, 1961, that (I) (we) last saw the deceased alive on October 17, 1961, end that death occured at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/18/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/21/61

23c. NAME OF CEMETERY OR CREMATORY: George Washington

23d. LOCATION (City, town or county) (State): Prince George Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.

25a. REC'D BY REGISTRAR DATE OCT 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11264

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN this place: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d. STREET ADDRESS: Liberty Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: TROY — Middle: — Last: TIPTON

4. DATE OF DEATH: Month: 10 — Day: 5 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 5, 1914

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: City Water Supply

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 242-34-7742

17. INFORMANT: Mr Dewey Bedford — Address: Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES T. MARSH

Address (Street, city, town, or county):

DATE SIGNED: 10-5-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-8-61

22c. NAME OF CEMETERY OR CREMATORY: Garland's

22d. LOCATION (City, town, or country) (State): Baltimore, Md.

23. FUNERAL DIRECTOR: Luther V. Haught — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: OCT 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11278 — 11265

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 11 mos. 9 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 28
   d. STREET ADDRESS: 500 Academy Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bertha — Middle: H. — Last: Straughn — Walbeck

4. **DATE OF DEATH**: Month: October — Day: 10, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 30, 1884

9. AGE (In years last birthday): 77 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Straughn

14. MOTHER'S MAIDEN NAME: Laura Steiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Mr. Howard O. Walbeck-500 Academy Road Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), end (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO (b): Old rheumatic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 31, 19 60 to October 10, 19 61 that (I) (we) last saw the deceased alive on October 10, 19 61, and that death occured at 7:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo MD M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10/11/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-13-61

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City, town or county) (State): Woodlawn, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W M J. Tschudy & Sons

ADDRESS: 1111 Pa. Ave. Balto. 17 Md.

25a. REC'D BY REGISTRAR: OCT 13 '61

25b. REGISTRAR'S SIGNATURE: Clarence S. Funnis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11279 — Reg. Dist. No. 11266

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Meadow View Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster Md RD#6
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ALFRED — Middle FRANKLIN — Last WELCH

4. DATE OF DEATH: Month OCT. — Day 22 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: June 19 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired - farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H. Welch

14. MOTHER'S MAIDEN NAME: Agnes Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

INFORMANT — Address: Mrs. Harry A. Dobson Westminster Md. RD#6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Nephritis (acute) — INTERVAL BETWEEN ONSET AND DEATH: 10-17-61

DUE TO (b): Myocarditis (chronic) — ? 10-19-61

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 590X

DUE TO (c): Pneumonia (viral) — 10-19-61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1961, to Oct 22, 1961, that I last saw the deceased alive on Oct 21, 1961, and that death occurred at 2.05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm C. Jennette M.D. — ADDRESS (Street, city or town, state): 103 E Main Westminster Md — DATE SIGNED: 10-23-61

PHYSICIAN'S NAME (Type): Wm C. JENNETTE M.D. 103 E MAIN WESTMINSTER Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/25/61 — 22c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery — 22d. LOCATION (City, town, or county) (State): Smallwood Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 24 '61 — 24b. REGISTRAR'S SIGNATURE: Clarence E. Keene

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11280 — Reg. Dist. No. 11267

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Westminster
d. STREET ADDRESS: 1314 Mary Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARJORIE Middle RUTH Last WELLER
4. DATE OF DEATH: Month OCT. Day 10 Year 1961
5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 29 1892
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-wife
10b. KIND OF BUSINESS OR INDUSTRY: clothing factory
11. BIRTHPLACE (State or foreign country): Union Mills, Carroll Co. Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: David H. Mausheimer
14. MOTHER'S MAIDEN NAME: Mary R. Sullivan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: 216-22-8018
INFORMANT: Donald S. Weller Address 314 Mary Ave. Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute myocardial infarction	12 hours
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary occlusion	12 hours
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/4 19 53, to 10/10 19 61, that I last saw the deceased alive on 10/16 19 61, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chepko M.D. ADDRESS (Street, city or town, state): 85½ W. Green St DATE SIGNED: 10/10/61
PHYSICIAN'S NAME (Type): Julius Chepko Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/12/61
22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
22d. LOCATION (City, town, or county) (State): Westminster Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster Md
24a. REC'D BY REGISTRAR DATE: OCT 13 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11281 — 11268

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Winfield
c. LENGTH OF STAY IN 1b: 41 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: P.O. Sykesville R. D. 2

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Near Winfield
d. STREET ADDRESS: P.O. Sykesville, R. D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: C. — Last: Wyatt
4. DATE OF DEATH: Month: October — Day: 30, — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 18, 1890
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Balto. City, Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas McJilton
14. MOTHER'S MAIDEN NAME: Dolly ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Charles A. Will, Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary thrombosis, Auricular fibrillation,	
420.1 DUE TO (b)	Arteriosclerotic heart dis., Cardiac	1960 to 30 Oct 61
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO (c)	failure, Arteriosclerosis Generalized.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City or tawn) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 19— to 30 Oct 1961, that (I) (we) last saw the deceased alive on 30 Oct 1961, and that death occurred 2:30 P M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.
22d. ADDRESS: Sykesville, Maryland 31 Oct 61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-2-1961
23c. NAME OF CEMETERY OR CREMATORY: Messiah Lutheran
23d. LOCATION (City, tawn, or county) (State): Carroll Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. Waltz, Winfield, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11282

CERTIFICATE OF DEATH

11269

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Finksburg R.F.D.1
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Louisville Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Corroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. STREET ADDRESS: Louisville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: George — Last: Yaeger

4. DATE OF DEATH: Month: Oct. — Day: 8, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 10, 1860

9. AGE (In years last birthday): 101 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Wire Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Philip Yaeger

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-09-4759A

17. INFORMANT Address: Bertram Yaeger, Finksburg RD1, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema.	24 h.
450.0 DUE TO (b)	Chr. Heart failure	3 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Generalized Arteriosclerosis	yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: e.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 7. 1. 19 59, to 10. 8, 1961, that (I) (~~we~~) last saw the deceased alive on Oct 3 1961, and that death occured at 9:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Sani Okutman M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Sani Okutman
22d. ADDRESS: Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 11, 1961
23c. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park
23d. LOCATION (City, town or county) (State): Taylor Ave. Baltimore

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

25a. REC'D BY REGISTRAR DATE: OCT 11 '61
25b. REGISTRAR'S SIGNATURE: Thos. S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11283 — 11270

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster Rural
c. LENGTH OF STAY IN 1b: 1yr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: W — Last: ZEPP

4. DATE OF DEATH: Month: Oct — Day: 7 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3-29-1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: State Road

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob ZEPP

14. MOTHER'S MAIDEN NAME: Sarah Keechner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 219-01-0199

17. INFORMANT: Earl Miller — Address: Westminster RD Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Nasopharynx
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
146X

INTERVAL BETWEEN ONSET AND DEATH: 1yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Yaer 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec, 1960 to Oct 7, 1961, that (I) (we) last saw the deceased alive on Oct 7 1961, and that death occured at 8 P M, from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W H Foard MD

22d. ADDRESS: Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 10/61

23c. NAME OF CEMETERY OR CREMATORY: Manchester

23d. LOCATION (City, town or county) (State): Carroll Co Md

FUNERAL DIRECTOR'S SIGNATURE: Pipkin Elmer

ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE OCT 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60